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Availability and Effectiveness of Programs to Treat Victims of the Methamphetamine Epidemic

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A Grassroots Perspective

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The following testimony is divided into sections addressing: Availability of Methamphetamine Treatment, Barriers to the Availability of Methamphetamine Treatment, Barriers to the Effective Treatment of Methamphetamine, and Recommendations for Rural Communities.

Availability of Methamphetamine Treatment

For most methamphetamine abusers, treatment options may be few and far between due to the severity of the addiction and sophistication of treatment needed to address it effectively. The Otis R. Bowen Center has had the opportunity to have the Matrix Institute from California come to Indiana to train its staff in the Matrix Model. We were able to provide this training through the support of our Local Coordinating Council (Drug Free Noble County), Judge Michael Kramer, Community Anti-Drug Coalitions of America (CADCA), and the Indiana Division of Mental Health and Addiction. Without the support of these organizations and individuals, it would have been extremely difficult to have this opportunity due to the cost of the training.

The Bowen Center has also had the opportunity to purchase the Matrix Model for all of our locations. The Noble County Office was able to purchase these materials through the support of Drug Free Noble County. Without the information and support that we receive through Drug Free Noble County (with the support of CADCA) we would have increased difficulty implementing this programing. The Indiana Division of Mental Health and Addiction also has the Matrix Model (except for the copyrighted materials) available for all of the community mental health centers in Indiana. Through CADCA and Drug Free Noble County, we have been able to access researched based information to assist with treatment for methamphetamine abusers.

Even with the support of all of these organizations, we are still having difficulty with the full implementation of the Matrix Model due to the issues that follow.

Barriers to the Availability of Methamphetamine Treatment

The first barrier to the availability of methamphetamine treatment in rural areas is the absence of qualified and experienced staff. Staff recruitment of individuals qualified to treat the chemical dependency population is extremely difficult. The Bowen Center is constantly and actively recruiting chemical dependency clinicians, but we continuously have open positions in all ten of our county offices. Incorporating the Matrix Model requires the implementation of very extensive programming in which clinicians spend intensive time in contact with individuals, referral agencies, families of those involved in treatment, courts, physicians, and facilitating treatment programs. To incorporate the Matrix Model would mean hiring at least 2 full time staff in each of the counties the Bowen Center serves. Since we have offices in ten counties, recruitment for these positions is extremely difficult. As a result of the absence of these qualified staff, rural areas have been left with actively recruiting staff within their agencies for the chemical dependency positions. This means that less experienced staff have to go through a rigorous, time consuming, and extensive process of education, training, and gaining field experience. This entire process is lengthy and expensive. All chemical dependency clinicians need to be trained not only in the Matrix Model, but also require training in motivational interviewing, contingency management, mental health issues, cognitive behavioral therapy, and relapse prevention. Dr. Thomas Freese of the Pacific Southwest Addiction Technology Treatment Center, summarizes this by saying, “training and development of knowledgeable

clinical personnel are essential elements to successfully address the challenges of treating MA [methamphetamine] users." Until rural areas have enough qualified, experienced staff providing these services, the outcomes for treatment will be effected. Rural areas are in need of additional resources for recruitment, training, and retaining qualified chemical dependency clinicians.

The next barrier is summarized by Dr. Freese, "training alone is insufficient if the funding necessary to deliver those treatment recommendations is not available." Treatment is not cheap, but it is less expensive to treat methamphetamine abusers than it is to incarcerate them. According to the Principles of Drug Addiction Treatment: A Research Based Guide (National Institute on Drug Abuse), "conservative estimates indicate that for every one dollar spent on treatment, four to seven dollars are returned in reduced crime, criminal justice costs, and theft." The Noble County Jail has a third of its population incarcerated for methamphetamine-related crimes, and they have spent (in the first 10 months) one-tenth of their medical budget on oral and dental damage from the use of methamphetamine.

The third barrier is the cost of the treatment to the methamphetamine abuser. According to Paul Brethen, MA, MFT, at The Matrix Institute, the cost for the full Matrix Model to clients is 6,000 dollars. Many methamphetamine abusers have been incarcerated for a long period of time, possess a felony drug charge, and have lost their homes, cars, and possessions due to use. They do not have the funding for food or shelter - let alone treatment. Those few methamphetamine abusers with managed care insurance may not be covered due to their legal difficulties, and if they are covered do not have the coverage they need due to managed care limited authorizations for services. For effective treatment, methamphetamine abusers and their families need to be involved with treatment. Family therapy is an additional cost to the abuser. Research also indicates that treatment should include case management services, because of the specific needs of the methamphetamine abuser. The addition of the case management costs is yet another obstacle to treatment for this population. The only way case management is funded is if the methamphetamine abuser has Medicaid and a mental health DSM-IV TR diagnosis. This would only include a very small percentage of those individuals we serve.

Another challenge for methamphetamine abuser is the geographical commute to a treatment provider. Transit systems such as buses, subways, etc.; do not exist in most rural communities. Even if a transit system does exist, the cost is prohibitive. Many individuals have lost their license and do have not vehicles for transportation. Even if they do have their license and a vehicle, they do not have money for gasoline.

Women present another interesting challenge as they tend to be the primary caregiver for the children in the home, and run the risk of pregnancy. In Indiana, 47% of those individuals abusing methamphetamine are women, and research has shown that women are less likely to seek treatment for their drug use than their male counterparts. Women have higher rates of depression, anxiety, poor self-esteem, sexual abuse, poverty, and lack of skills necessary for employment which all become additional barriers to treatment. In addition to those barriers, women often need child care services which further adds to the cost of treatment.

Another way to increase the effectiveness of treatment is to separate men, women, and adolescents as each of these groups presents interesting challenges in terms of treatment. In rural areas where implementing one program is difficult, the possibility of three separate programs to address these needs is minimal.

Another additional barrier to methamphetamine treatment is the availability of detoxification and on-going residential treatment. The Washington House, a detoxification and short term residential program, is closing its doors as of June 30, 2006, due to lack of funding. As a result, the initial process of treatment for methamphetamine abusers is going to fall back onto local hospitals, mental health inpatient facilities, and jails. The detoxification process for methamphetamine is recommended to be a minimum of several days to two weeks. On-going residential treatment for 30 days or more is also recommended. Most medical and mental health facilities do not have the funding, bed space, staff, or resources to detoxify a person from methamphetamine - let alone provide the residential aspect of treatment needed for the methamphetamine abuser to regain some essential thinking and decision making skills.

Barriers to the Effectiveness of Methamphetamine Treatment

The National Institute on Drug Abuse (NIDA) reports that "amphetamines are the most potent of all the stimulant drugs in that they cause the greatest release of dopamine, more than three times that of cocaine." Whereas cocaine affects the brain cells for a very short amount of time, methamphetamine stays at the brain site and produces the release of dopamine for 6 to 12 hours. This results in increased damage to the brain cells and structure of the brain. Most methamphetamine users have greatly impaired memory, learning impairments, great difficulty with decision making skills, inattention, distractibility, performance on motor and verbal memory tests, psychosis, and increased depression. Dr. Freese also discusses other deficits such as "deficits on executive tasks associated with poor judgment, lack of insight, poor strategy formation, impulsivity, reduced capacity to determine consequences of actions." As a result, treatment needs to be long-term, intensive, and comprehensive to include not only issues for methamphetamine abuse but also medical, psychiatric, and mental health issues. Another barrier is that rural areas have difficulty with recruiting and retaining psychiatrists. The Matrix Model is an evidenced based program used to treat methamphetamine abusers that meets the criteria for duration and intensity of treatment.

With the use of the Matrix Model, methamphetamine treatment is effective. The Matrix Model assists with improving the effectiveness of treatment due to the following; the use of multiple learning methods, the explicit structure and expectations, the establishment of a positive, collaborative relationship with the client, the education on important recovery issues, the positive reinforcement of desired behavioral changes, and the involvement of family in the treatment process. It also introduces and encourages self-help participation and uses drug testing to monitor use.

Research also indicates that the ability to engage and retain clients in treatment is often the factor separating the effective treatment programs from those that are not. The Matrix Model assists with the utilization of motivational interviewing with establishing a positive, therapeutic relationship to build and foster feelings of self-worth. Motivational interviewing allows for increasing client engagement in the recovery process. Methamphetamine abusers need to be engaged in this process for treatment to be effective. They also need to be treated with dignity, warmth, and respect. Motivational interviewing may also be utilized to decrease the paranoia that many methamphetamine abusers feel when entering treatment. By establishing a positive and therapeutic relationship, it allows the clinician to provide corrective feedback.

Another aspect of the Matrix Model is contingency management. Research indicates that contingency management is effective in offering rewards for attendance, clean urine screens, and other identified positive behaviors. By rewarding positive behaviors it greatly stimulates the continuation of that behavior. The barrier in utilizing contingency management is that there are no funds available to support it.

In rural areas, it is likely that we have never experienced the cocaine epidemic. As a result, the treatment that needs to be done with methamphetamine abusers is new and may feel like an uphill battle to both clinicians and methamphetamine abusers. Dr. Richard Rawson notes "people addicted to methamphetamine respond to treatment as well as do people addicted to other drugs such as cocaine." As previously mentioned, until rural areas have enough qualified and experienced staff, the outcomes will be affected.

Methamphetamine abusers may have difficulty linking to self-help groups due to the absence of specific methamphetamine groups in rural communities. Whereas in most communities, individuals can be linked to Alcoholics Anonymous, there are few groups that address the unique needs of the methamphetamine abusers. This results in many feeling misunderstood. In addition, many methamphetamine abusers may not want to attend a self-help group in rural communities due to concerns regarding confidentiality and feeling a lack of anonymity.

Recommendations for Rural Communities

1. Continued and increased support of the Substance Abuse Prevention and Treatment (SAPT) Block grant. In Indiana, the SAPT funds over 70% of all addiction services and 95% of prevention services.
2. Continued support of the Community Anti-Drug Coalition (CADCA) which assists communities with resources, linkage to national science based resources, and the assistance with the development of community based interventions to assist in the prevention and treatment of alcohol and drug abuse.
3. Assist rural communities with resources for staff recruitment, retention, and training.
4. Enhancing psychiatric, medical, educational, pre-vocational, vocational, transportation, parenting, and employment opportunities.
5. Resources to provide child care for those involved in methamphetamine treatment.
6. Expand access to treatment and the treatment infrastructure.
7. Enhance tools to share knowledge and best practices.
8. Resources for contingency management.

References

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